STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING _____ B. WING _____	C 07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification and Abbreviated Survey related to ARO KY00015063 was conducted on 07/20-22/10. Deficiencies were cited at the highest scope and severity of an "E". A Life Safety Code Survey was conducted with no deficiencies cited. KY00015063 was determined to be substantiated with no deficient practice identified.	F 000	The Bluegrass Care and Rehab does not believe and does not admit that any deficiencies exist, before, during and after the survey. The Bluegrass care and Rehab reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the (Facility Name) reserves al right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this Plan or Correction should be considered as a waiver of any potential applicable Peer Review, Quality Assurance or self critical examination privileges which the Bluegrass Care and Rehab does not waiver, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceedings. Bluegrass Care and Rehab offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

RECEIVED
AUG 13 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Adm	8-13-10

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to immediately inform the Responsible Party/Power of Attorney of a significant medication error involving one (1) of twenty-one (21) sampled residents (Resident #11). The findings include: Review of Resident #11's clinical record revealed diagnoses which included Encephalopathy, Motor Neuron Disease, ESRD (End-Stage Renal Disease), and Hypothyroidism. Based on the most recent MDS (Minimum Data Set) completed 05/05/10, revealed the facility assessed the resident as having long and short-term memory deficit, impaired cognitive skills, and great difficulty with communicating. The resident required extensive assistance with all ADLs (Activities of Daily Living), and attended dialysis three (3)times per week. Review of Resident #11's clinical record revealed that, on 07/01/10, due to a conflict with early morning trips to the dialysis clinic, the scheduled times for several medications had to be changed from 6:30 AM to 11:00 AM. The medications included doses of Ranitidine 150 mg. (milligram), Risperidone 0.5 mg., Vitamin B-1 50 mg., Exelon Patch, Folic Acid 1 mg., Namenda 5 mg., Nephro-Vite, Plavix 75 mg. and Levothyroxine 0.125 mg (a medication used for the thyroid).	F 157	F 157 1. The physician and family were notified of the omission of the order for resident #11 by the ADON on 07/22/10. An order was obtained to restart the medication as ordered and was restarted on 07/21/10. 2. All resident's physician's orders were reviewed DON/ADON, 7/31/10 to ensure Physician and Family notification occurred for all residents with a change of condition or order change over the last 30 days. Corrective action was completed as indicated. 3. An In-service was completed by DON/ADON /designee 07/22/10 for licensed nursing staff regarding physician and family notification when a change in a resident's condition and/or changes in physician's orders occurs. When there is a change in the resident's condition, staff will record physician and family notification in the medical record. Medical records will be reviewed by the Interdisciplinary Team in the clinical meeting five days weekly and by the Weekend Supervisor on weekends to ensure that physician and families have been notified as required of a change in a resident condition or medication change, and that documentation of notification of physicians and families are appropriately completed in the clinical record.	

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F 157	Continued From page 2 The resident's 6:30 AM dose of Simvastatin 20 mg. was switched to 9 PM. Subsequently, the schedule times of all the medications (with the exception of the Levothyroxine) were switched from 6:30 AM to 11:00 AM. However, the Levothyroxine order was never re-scheduled or re-transcribed to the Medication Administration Record (MAR); and, therefore were not administered to the resident from 07/01/10 through 07/21/10. Further record review revealed no evidence the Levothyroxine order had been discontinued. Following the discovery of the discrepancy involving Resident #11's Levothyroxine order, the South Wing Assistant Director of Nursing was interviewed at approximately 12:00 (noon) on 07/21/10. The nurse reviewed the resident's orders at that time and confirmed the Levothyroxine order had never been re-transcribed to the MAR at the corrected time of "11 AM", nor had the order been completely discontinued. Later that afternoon at approximately 3:00 PM, review of the resident's record revealed the Physician had responded that day at 12:30 AM by reordering the Levothyroxine to be resumed and to re-check the resident's TSH (Thyroid Stimulating Hormone), an index of the resident's thyroid function, on the following morning. On 07/22/10 PM at 5 PM, during an interview with the Power of Attorney (POA) of Resident #11, when asked if he/she had been informed of any recent changes in the resident's medication therapy, the POA responded "No". At 5:30 PM that day, during an interview with the Administrator and the Director of Nursing, neither individual had been aware the POA had not been	F 157	4. The Director of Nursing or Assistant Director will complete a 10% audit of resident's charts weekly to ensure that physician and family notification has occurred as required. Corrective actions will be completed as indicated. Findings will be reported to the Quality Assurance Committee monthly for 6 months for recommendations and further follow-up as indicated.	8/23/10

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F 157	Continued From page 3 notified of the discovery of the medication error on the previous day. Shortly thereafter, during a meeting attended by the Administrator, Registered Nurse (RN) #2, and Licensed Practical Nurse (LPN) #7, LPN #7 explained she had notified the POA of the medication error earlier that morning (07/22/10) as the resident was being picked-up by the POA to go to the dialysis clinic. The LPN stated "I thought it would be better to explained the incident in person rather than by reporting by phone". No documented evidence was provided related to Resident #11's POA being immediately notified of the medication error.	F 157		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a clean and homelike environment for residents on the Southwest resident wing. A strong odor which was noted on the entire hallway of resident rooms on 07/21/10 and 07/22/10. The problem was acknowledged to be a long term issue by facility staff. The findings include: Interview on 07/21/10 at 3:40 PM with Registered	F 252	F252 1. Resident's rooms on the South Hall was audited for odors by the Director of Nursing and Housekeeping Supervisor on 7/21/10. The mattress for one resident identified with odor in her room was changed out by the Housekeeping Supervisor on 07/21/10. The identified resident's soiled clothes were doubled bagged and placed in her hamper (family does laundry). The Family was notified by the Social Services Director that soiled linen needs to be picked up for laundering. No other sources of pervasive odors were identified.	

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F 252	Continued From page 4 Nurse (RN) #3 revealed she was aware of the odor on the Southwest resident wing since the start of her employment at the facility four (4) months ago. Further interview revealed RN #3 attributed one source of the odor to be a specific resident in one of the rooms who was noncompliant with personal hygiene and also hung urine and feces soiled clothes in his/her room closet. Further interview with RN #3 revealed that, in addition to trying to locate source(s) of odor, the facility was "holding staff more accountable" for measures to eliminate odors. Interview on 07/21/10 at 3:55 PM with the Director of Nurses (DON) who had been employed at the facility for the past four (4) months revealed the specific, above noted resident frequently refused required assistance with hygiene. Interview on 07/22/10 at 10:00 AM with RN #1 revealed the facility had an ongoing problem with odors on the Southwest resident wing and that she "keeps looking" for the source of odor. RN #1 also attributed one source of the problem to be the previously-mentioned resident. Interview on 07/22/10 at 9:30 AM with the Housekeeping Employee assigned to the Southwest Wing for the past eight (8) months revealed she had noticed the odor there on a daily basis. Further interview with the employee revealed she thought some of the odor was imbedded in the floors and tiles in some patient rooms. The housekeeper revealed she referred the problem to the supervisor when odors were not eliminated by her efforts. Interview on 07/22/10 at 10:00 AM with the	F 252	2. An audit of the facility was completed by department mangers on 07/23/10 and no further concerns where identified. 3. The identified Resident's room will be audited by assigned department managers daily for odors and appropriate corrective action will be taken upon identification. Nursing Assistants will observe resident's closets each shift of their assigned residents to ensure soiled clothing is stored in a closed linen hamper as required with identified concerns reported to the Charge Nurse. The Social Services Director will be notified when a resident's soiled clothing has not been picked up by family members in a timely manner, when the family has indicated that they will be responsible for the resident's laundry. Housekeeping staff will clean resident's mattresses weekly. In-service education will be provided to Nursing Staff and Housekeeping Staff on 8/17/10 by the Director of Nursing and Housekeeping Supervisor regarding identification of odors in resident's rooms and throughout the facility and appropriate	

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F 252	Continued From page 5 Director of Laundry and Housekeeping revealed she denied noticing offensive odors on the Southwest resident wing on a daily basis. Further interview with the Director revealed if she did detect an odor on any hallway, she would talk to the housekeepers assigned to those areas and would often assist them in locating the source. Interview with Resident #14 revealed the resident detected the presence of "bad odors" occasionally. The resident reported spending most of his/her time (by choice) in his/her room.	F 252	corrective actions to be completed when odors are identified. Included in the in-service was the required closet/soiled clothing checks, cleaning of mattresses, and corrective actions to be taken when an odor is identified. 4. The Housekeeping Supervisor will audit 5 resident rooms daily to ensure any odors are kept to a minimum. Weekly rounds will be completed throughout the facility by the Administrator to ensure that odors are identified, and a plan is initiated to correct identified concerns. Findings of the above stated audits will be discussed in the Quality Assurance Meeting monthly for 6 months for recommendations and further follow-up as indicated.	8/23/10
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to complete Quarterly Minimum Data Set assessments for one (1) of twenty-one (21) sampled residents within the ninety-two (92) day timeframe. The findings include: Review of Resident #7's clinical record revealed diagnoses with included Diabetes, Chronic Depression and History of Urinary Track Infection. Review of Resident #7's Minimum Data Set (MDS) assessments revealed the facility completed a Quarterly MDS assessment 01/11/10, date the Register Nurse signed as	F 276	F276 1. A review of Resident #7's clinical record was completed by the MDS Coordinator on 7/21/10 for the appropriate time frame for assessment completion. The quarterly MDS assessment was found to be completed 28 days late.	

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F 276	Continued From page 6 complete. The review revealed the next assessment completed by the facility was a Quarterly MDS assessment which was dated 05/12/10, date the Register Nurse signed as complete. This reflected one hundred twenty-one (121) days from Resident #7's previous Quarterly assessment therefore; surpassing the required timeframe of ninety-two (92) days. Interview with MDS Coordinator on 07/21/10 at 10:55 AM revealed MDS assessments were to be conducted within the ninety-two (92) day timeframe. The MDS Coordinator stated she was not employed as the MDS Coordinator at the time Resident #7's Quarterly assessment was due, and could offer no insight regarding the lateness of Resident #7's assessment.	F 276	2. MDS Assessments for all residents were reviewed by the MDS Coordinators on 8/10/10 to ensure they have been completed within the required timeframe. 3. Education will be provided to the MDS Coordinators by the Director of Nursing on 8/13/10 regarding timely completion of MDS Assessments based on guidelines. The MDS Coordinator will print a copy of the Next MDS due report after each transmission of MDS Assessments weekly. This report will be compared with current MDS schedule by the Director of Nursing to ensure assessments are completed in a timely manner in accordance with guidelines. 4. The MDS Coordinator will print MDS Due report monthly to ensure MDS assessments have been completed in accordance with guidelines. Findings of this report will be discussed in the monthly Quality Assurance Meeting for 6 months recommendations and further follow-up as indicated.	8/23/10
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure residents were free of significant medication errors. It was determined on 07/21/10 Resident #11, as the result of a transcription error, failed to receive an ordered dose of Levothyroxine 0.125 mg. (milligram) for twenty-one (21) consecutive days during July 2010. The findings include: Review of Resident #11's clinical record revealed diagnoses which included Encephalopathy,	F 333		

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F 333	Continued From page 7 Motor Neuron Disease, End-Stage Renal Disease (ESRD), and Hypothyroidism. Based on the most recent MDS (Minimum Data Set), an admission assessment completed on 05/05/10, the facility assessed the resident as having long and short-term memory deficits, moderately-impaired cognitive skills, and great difficulty in communicative ability. The resident was assessed by the facility as requiring extensive assistance with all Activities of Daily Living. The resident received dialysis services three (3) days per week. Review of Resident #11's clinical record revealed that, on 07/01/10, due to a conflict with early morning trips to the dialysis clinic, schedule times for several morning medications had to be changed from 6:30 AM to 11:00 AM. Those medications consisted of Ranitidine 150 mg., Risperidone 0.5 mg., Simvastatin 20 mg., Vitamin B-1 50 mg., Exelon Patch, Folic Acid 1 mg., Namenda 5 mg., Nephro-Vite, Plavix 75 mg. and Levothyroxine 0.125 mg. Review of the physician's orders revealed all medications were switched to 11:00 AM administration, except the Simvastatin which was changed to "9 PM. However, the order for the for Levothyroxine was never re-transcribed to the MAR (Medication Administration Record) and was, thus, never administered to the resident from 07/01/10 through 07/21/10. There was no documented evidence the ordered Levothyroxine had been discontinued. After discovery of the apparent discrepancy involving Resident #11's Levothyroxine order, the South Wing Assistant Director of Nursing (LPN #7) was interviewed at approximately 12:00 noon on 07/21/10. The nurse reviewed the resident's	F 333	F333 1. The physician and family were notified of the omission of the order for resident #11 by the ADON on 7/22/10. Physician's orders were obtained and the medication was restarted on 7/21/10. 2. Physician's orders were reviewed for all residents by 7/31/10 and compared to the Medication Administration Record by two Nurses for each resident to ensure that no other transcription errors had occurred. No further concerns were identified. 3. Licensed Nursing Staff will receive in-service education on 8/17/10 by the Director of Nursing regarding the importance of ensuring transcription of physician's orders to the MAR is accurate, and the requirement of 2 Nurses reviewing transcription to ensure accuracy. New orders will be reviewed by the Interdisciplinary Team in the clinical meeting five days weekly and by the Weekend Supervisor on	

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F 333	Continued From page 8 orders at that time and confirmed the Levothyroxine order had never been re-transcribed to the MAR at the corrected time of "11 AM" nor that the order had been completely discontinued. Later that afternoon at approximately 3:00 PM, review of Resident #11's record revealed the Physician had responded at 12:30 PM that day by reordering the Levothyroxine to be resumed and scheduled at 11:00 AM each day, and to re-check the resident's TSH (Thyroid Stimulating Hormone), an index of the resident's thyroid function, on the following morning. On the afternoon of 07/22/10 at 3:45 PM, during a follow-up interview with LPN #7, she described the error involving Resident #11's Levothyroxine was "an error which should not have happened" and stated "I will be working on a better system and will probably be auditing all new orders after this". Based on Resident #11's diagnosis (Hypothyroidism), because of the medication's narrow therapeutic index and need for titrating the dosage to an optimum level, and the fact that the medication was omitted from the resident for twenty-one (21) consecutive days, it was deemed to be a significant medication error.	F 333	weekends, and compared to the Medication Administration Record to ensure appropriate transcription of a change in medication orders. 4. The ADON will complete a 10% audit of residents charts weekly and compare to the Medication Administration Record to ensure that physician's orders are transcribed appropriately. Findings of the above stated audit will be discussed in the monthly Quality Assurance Meeting for 6 months for recommendations and further follow-up as indicated.	8/23/10
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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F 431	Continued From page 9 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure storage of insulin under proper temperature controls as specified by its provider pharmacy and facility policy. Inspection of four of eight medication carts revealed the presence of three (3) vials of unopened insulin in one of the carts, all of which had been dispensed up to a week or more prior to the inspection and which had remained outside of refrigeration.	F 431	F431 1. The 3 vials of insulin that were discovered to be unopened and stored outside the refrigerator were removed from the cart. 2. All medication carts were reviewed by the Assistant Directors of Nursing to ensure unopened insulin vials were not stored on the medication cart. No other concerns were identified.	

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F 431	Continued From page 10 The findings include: On the afternoon of 07/22/10, inspection of Medication Cart #3 on the South Wing revealed the presence of three unopened vials of insulin consisting of one vial of Novolog and one vial of Humulin-R (both dispensed on 07/12/10) and one vial of Lantus (dispensed on 07/15/10). When questioned about the facility's policy relative to the storage of insulins, LPN #5 explained vials of insulin were automatically placed in the medication cart immediately upon receipt from the pharmacy. During a subsequent interview with LPN #7, she agreed with LPN #5, adding "When we receive insulins from the pharmacy, we usually place them directly into the medication cart since they are usually put into use within a day or two". Inspection of Medication Cart #1 revealed the presence of several opened vials of insulin (all dated when opened), but no unopened vials. Two of the four medication carts on North Wing were also inspected on the afternoon of 07/22/10, but revealed no unopened vials of insulin. However, during an interview at 5:15 PM with RN #1, the North Wing Assistant Director of Nursing, she explained "When we receive insulins from the pharmacy, we place them directly in the medication cart- not in the refrigerator". At approximately 5:15 PM on 07/22/10, during an interview with the Director of Nursing (RN #4), she was asked to furnish a copy of the facility's policy related to the storage of insulin. At approximately 5:30 PM, she produced a form titled "Guidelines for Discarding Opened Multidose Products". The document instructed	F 431	3. Licensed nurses received in service education on 7/29/10 by the Director of Nursing and the Staff Development Coordinator regarding the policy and proper procedure for storage of unopened insulin. 4. Assistant Director of Nursing will complete a weekly audit of medication carts to ensure that vials of unopened insulin are not stored on medication carts. Findings will be forwarded to the Director of Nursing for corrective actions as indicated, and will be discussed in the monthly Quality Assurance meeting for 6 months for further recommendations and follow-up as indicated.	8/23/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING _____ B. WING _____	C 07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 431	Continued From page 11 staff that all listed items (including all vials of insulin) "Must be kept refrigerated until opened". Once opened, all vials were to be dated and allowed to be maintained at room temperature (inside the medication cart), and then replaced "after 28 days".	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 1. No specific residents were identified in this cite. 2. All Residents have the potential. Facility staff received in-service education on 729/10 regarding the requirement to wash their hands between each direct resident contact. 3. An Infection Control In-service was held on 08/3/10 and 8/5/10 for facility staff with emphasis on the requirement for soap and water hand washing to be completed following direct resident contact with emphasis on meal service. The Staff Development Coordinator completed a review for Nursing Assistants with return demonstration of appropriate hand washing on 7/29/10.	

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	185446	A. BUILDING _____ B. WING _____	C 07/22/2010

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F 441	Continued From page 12 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure staff washed their hands after each direct resident contact for which hand washing was indicated, per the facility's policy. The findings include: Review of the facility's "Handwashing/Hand Hygiene" policy,noted to have been revised August 2008, revealed "Employees must was there hand for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:" "a. Before and after direct contact with residents;". Observation of the noon meal on 07/20/10 at 12:40 PM revealed Certified Nursing Aide (CNA) #3 made direct contact with three un-sampled residents without washing/sanitizing her hands. CNA #3 was observed to be seated at a table assisting three (3) residents with their meal. The CNA was observed to touch one resident on the leg, touched a second resident on the hand, touched the first resident on the leg again, touched a third resident on the hand, and touched the first resident on the leg again prior to getting up to use a sanitizing station on the wall nearby. Interview with CNA #3 on 07/22/10 at 11:35 AM	F 441	4. The Nursing Management Team will review meal service 3 times weekly to ensure appropriate hand washing between resident contacts. Corrective actions will be completed immediately upon identification of a concern. Findings of the above stated audits will be discussed in the monthly Quality Assurance Meeting for 6 months for recommendations and further follow-up as indicated.	8/23/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING _____ B. WING _____	C 07/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 441	Continued From page 13 revealed the CNA was knowledgeable regarding the need to sanitize her hands between each direct resident contact. CNA #3 stated she did not have her small bottle of hand sanitizer on 07/20/10 during the noon meal, as there was no hand sanitizer available in the supply closet. CNA #3 states that hand sanitizer was usually available in the supply closet.	F 441	1. The Plant Operations Manager secured the identified handrails upon identification of the concern. 2. The Plant Operations Manager completed rounds throughout the	
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the failed to ensure the corridors were equipped with firmly-secured handrails. The findings include: Observations during the survey revealed the handrails in the facility corridor extending from the Activities Office to the Director of Nursing's Office, an area of thirty five (35) feet, were loose/unsecured. The Plant Operations Manager verified the section of handrails were loose and indicated he would order replacement handrails.	F 468	facility on 7/23/10 to ensure that handrails were secured as required. No further concerns were identified. 3. In-service education was provided to the Plant Operations Manager by the Administrator on 7/23/10 regarding the importance of ensuring handrails are appropriately secured throughout the facility. The Plant Operations Manger will complete an audit weekly throughout the facility to ensure that for handrails are appropriately secured. Corrective actions will be completed immediately upon identification of concerns. 4. The Administrator will complete an audit throughout the facility monthly to ensure handrails are secured appropriately. Findings of the above stated audits will be discussed in the monthly Quality Assurance Meeting for 6 months for further recommendations and follow-up as indicated.	8/23/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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K 000	INITIAL COMMENTS A Life Safety Survey was conducted on 07/21/10, in accordance with Title 42, Code of Federal Regulations, 483.70 (a) (Life Safety from fire, requirements for Long Term Care Facilities) and found the facility in substantial compliance with NFPA 101 Life Safety Code 2000 Edition.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Adm	8-13-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.